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NOV 28 2011

OFFICE OF INSPECTOR GENERAL

Application for License to
Operate a Long-term Care Facility

For Office Use Only
Received 11/29/11
Amount 2250.00

I. IDENTIFICATION

Kings Lexington 6650

Name Northpoint Lexington Healthcare
Address 1500 Trent Blvd.
City/County/Zip Lexington KY 40515
Telephone number (859) 272-2273
Administrator Elizabeth Thornton
Date facility operation began at current address 4/1989
Date facility began operation under current owner 3/2003

II. TYPE BEDS	No. beds licensed	No. beds requested
Skilled	_____	_____
Nursing Home	<u>150</u>	_____
Nursing Facility	_____	_____
Intermediate Care	_____	_____
ICF/MR	_____	_____
Personal Care	_____	_____

II. CONTROL (check one in each column)

State	Profit	Individual
County	Nonprofit	Partnership
City		Corporation
Private		

II. OWNERSHIP

Name and address of individual owner, partners or corporation. If partnership, list partners.

Northpoint Senior Services KY LLC dba
Northpoint Lexington Healthcare Center
7400 New La Grange Road Suite 100
Louisville KY 40222

(OVER)

If facility owned or leased by a corporation, complete the following:

Name of corporation Northpoint Senior Services LLC
Address of corporation 7400 NewlaGrange Rd Suite 100
Louisville, KY 40222
President or Chairman Bob Norcross
Vice President _____
Secretary _____
Treasurer _____

Attach a separate sheet listing the names and addresses of each person having at least a twenty-five (25) percent ownership interest in the facility.

If owned by a corporation, attach a separate sheet listing the names and addresses of each officer or director of the corporation.

If owned by a partnership, attach a separate sheet listing the names and addresses of each partner.

Name and address of parent corporation and/or management company, if applicable.

Parent	Management Company
_____	_____
_____	_____
_____	_____

I understand that any change in the application that affects my licensure status will be reported to the Office of Inspector General and a new application will be completed at that time. I agree that this facility and all aspects of its operation shall be open at all times to inspection and surveillance by all state agency licensure personnel. I certify that the information given in completing this application is accurate to the best of my knowledge and recognize that falsification of this application can result in denial or revocation of licensure.

Elizabeth Thornton Administrator 6/30/2011
Signature of authorized representative Title Date

Return Application and fee to:

Office of Inspector General
275 East Main Street, 5E-A
Frankfort, Kentucky 40621

OIG 5
(10/2002)